Wisconsin Department of Safety and Professional Services

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**
E-Mail: web@dsps.wi.gov
Website: http://dsps.wi.gov

RADIOGRAPHY EXAMINING BOARD

LIMITED X-RAY MACHINE OPERATOR (LXMO) PERMIT

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth
_____ _____ _____
month day year

Daytime Telephone Number
( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? _____Yes _____No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

High School Name: _____

School Address: _____
(City) (State)

Date of Diploma/GED Granted: _____
month/day/year

APPLICATION FEES

Make check payable to Department of Safety and Professional Services and attach to application.

☐ $75.00 Initial Credential Fee
$15.00 ARRT Contract Exam Fee
$90.00 Total Fee attached

Plus one or more of the following examinations (choose which exam(s) you are applying for):

- ☐ *ARRT thorax, lungs, ribs.
- ☐ *ARRT upper and lower extremities, including pectoral girdle but excluding hip and pelvis.
- ☐ *ARRT foot, ankle and lower leg below the knee.
- ☐ *ARRT cervical, thoracic and lumbar spine.

*Wisconsin Limited Scope Examination and Fee (once you receive DSPS authorization to sit for the Limited Scope Exam, you will receive further notification from DSPS to register online at www.arrt.org and pay the appropriate limited scope exam fee directly to ARRT.)

For Receipting Use Only

Wisconsin Department of Safety and Professional Services

YOUR APPLICATION WILL NOT BE CONSIDERED COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED BY THE DEPARTMENT.

- Application Form (#2903)
- Required fee

RADIOGRAPHY COURSE OF STUDY:

Institution	Location	Dates Attended	Degree(s)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LICENSURE IN OTHER JURISDICTIONS:

IF YOU ARE NOW OR HAVE EVER BEEN REGISTERED, CREDENTIALED OR LICENSED IN ANOTHER STATE OR U.S. TERRITORY, PLEASE LIST BELOW THE JURISDICTION AND STATUS OF YOUR LICENSE OR CREDENTIAL.

Credential/License	Jurisdiction	Status

(Request verifications of credential from the licensing authority where credentialed.)

Wisconsin Department of Safety and Professional Services

This section is required for all applicants.

APPLICANT – GENERAL HISTORY:
(Attach additional sheets if necessary)

1. Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any state or jurisdiction, or have you ever been a defendant in a military court-martial? Do not include parking or speeding violations. Include OWI, DUI.

   Yes _____ No _____ If yes, please list date, jurisdiction (state and county), offense, disposition and all relevant information:

_____

_____

_____

2. Have you ever been the subject of any disciplinary action by the licensing authority of any state or jurisdiction or are you the subject of any pending investigation or disciplinary action?

   Yes _____ No _____ If yes, provide details and documentation:

_____

_____

_____

3. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction?

   Yes _____ No _____ If yes, give details on an attached sheet, including the name of the profession and the agency.

_____

_____

_____

4. Have any suits or claims ever been filed against you as a result of professional services?

   Yes _____ No _____ If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.

5. Are you registered or have you been licensed or credentialed in any other profession(s)?

   Yes _____ No _____ If yes, state what profession(s) and in what state(s) and what name(s).

_____

_____

_____

6. Have you ever been terminated from any employment related to the practice of radiography?

   Yes _____ No _____ If yes, please provide details.

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.)

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as a limited x-ray machine operator with reasonable skill and safety" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical decisions and exercise reasoned radiography judgments and to learn and keep abreast of radiography developments and trends; and
2. The ability to communicate those judgments and radiography information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform LXMO tasks, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

		YES	NO
7.	Do you have a medical condition which in any way impairs or limits your ability to practice as a LXMO with reasonable skill and safety? **If yes, please explain.**	❑	❑
8.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? **If yes, please explain.**	❑	❑
9.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? **If yes, please explain.**	❑	❑
10.	Do you use chemical substance(s) which in any way impair or limit your ability to practice as a LXMO with reasonable skill and safety? **If yes, please explain.**	❑	❑
11.	Have you ever been diagnosed as having or have you ever been treated for paraphilic disorders (e.g., pedophilia, exhibitionism or voyeurism)? **If yes, please explain.**	❑	❑
12.	Are you currently engaged in the illegal use of controlled dangerous substances?	❑	❑
13.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **If yes, please explain. If your answered no for #12, leave blank.**	❑	❑

CERTIFICATION OF LEGAL STATUS.

I declare under penalty of law that I am (check one):

_____ a citizen or national of the United States, or

_____ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

ALL APPLICANTS MUST COMPLETE THIS SECTION

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

_____ _____

Signature of Applicant Date

Wisconsin Department of Safety and Professional Services

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____

First Name **Middle Initial** **Last Name**

_____

Profession

Date of Birth _____ _____ _____
month day year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department ofChildren and Families for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

EMAIL ADDRESS:
Do you have an email address? ☐ **Yes** ☐ **No**

If yes, this field is required to receive your application status electronically. Your email address must be clearly legible with the correct case sensitive information.

EMAIL ADDRESS: Submit your email address in the spaces provided below or attach a printer copy.

If no, your checklist will be sent by first class mail.

---

[1] Section 440.03 (11m), Wis. Stats.
[2] Sections 49.22, and 440.13, Wis. Stats.
[3] Section 440.12, Wis. Stats.
[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.